FACT SHEET: RELIEF PAYMENTS TO HEALTH PROVIDERS

The Department of Department of Health and Human Services (HHS) has announced an initial $30 billion in immediate relief funds to be distributed to Medicare facilities and providers. Payments started to arrive via direct deposit on April 10, 2020 to eligible recipients. **These payments are not loans and will not need to be repaid**.

Eligibility & Process

All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible. All payments are made to the billing organization according to its Taxpayer Identification Number (TIN). For example, individual physicians and providers in a group practice are unlikely to receive individual payments directly, as the group practice will receive the relief fund payment as the billing organization.

Automatic payments will come to providers via Optum Bank with "**HHSPAYMENT**" as the payment description. Providers who normally receive paper checks from the Centers for Medicare and Medicaid Services (CMS) will receive a paper check in the mail within the next few weeks.

Amount of Payment

Providers will receive a portion of the initial $30 billion based on their share of total FFS revenue in 2019. Providers can estimate their payment by dividing the 2019 Medicare FFS payments (not including Medicare Advantage) they received by $484,000,000,000 and multiply that ratio by $30,000,000,000. Providers should be able to obtain their 2019 Medicare FFS billings from their organization's revenue management system.

Attestation & Terms and Conditions

Recipients **must sign an attestation** confirming receipt of the funds and agreeing to the **terms and conditions** within 30 days of receiving payment. The portal for signing the attestation will be open the week of April 13, 2020, and will be linked on this **page**.

As a condition to receiving these funds, Recipients must:

- Certify that it billed Medicare in 2019; providers or provided after January 21, 2020 diagnosis, testing, or care for individuals with possible or actual cases of COVID-19; is not terminated from participation in Medicare; is not currently excluded from participating on Medicare; and does not currently have Medicare billing privileges revoked
- Certify that the payment will only be used to prevent, prepare for, and respond to coronavirus
- Certify that it will not use the payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse
- Submit reports as the Secretary determines are needed to ensure compliance
- Agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider
- No later than 10 days after the end of each calendar quarter, any Recipient that is an entity receiving more than $150,000 total in funds, shall submit to the Secretary and the Pandemic Response Accountability Committee a report

Additional Information

Providers that receive payment and do not wish to comply with these Terms and Conditions must do the following: contact HHS within 30 days of receipt of payment and then remit the full payment to HHS as instructed.

This relief payment is different than the CMS Accelerated and Advance Payment Program. The CMS accelerated and advance payment program are a loan that providers must pay back.